Iowa Medicaid Enterprise
CMS-1500 Claim Form Instructions
Health Insurance Claim Form

The following Iowa Medicaid provider types bill for services on the CMS-1500 claim form: Ambulance, Ambulatory Surgical Centers, Area Education Agencies, Audiologists, Birthing Centers, Certified Registered Nurse Anesthetists, Chiropractors, Clinics, Community Mental Health Clinics, Family Planning Clinics, Federally Qualifying Health Centers, Hearing Aid Dealers, Independently Practicing Physical Therapists, Lead Investigation Agencies, Maternal Health Centers, Medical Equipment and Supply Dealers, Nurse Midwives, Opticians, Optometrists, Orthopedic Shoe Dealers, Physicians, Rural Health Clinics and Screening Centers.

The billing instructions below contain information that will aid in the completion of the CMS-1500 claim form. The table follows the claim form by field number and name, giving a brief description of the information to be entered, and whether providing information in that field is required, optional or conditional of the individual recipient's situation.

For electronic media claim (EMC) submitters, refer also to your EMC specifications for claim completion instructions.

If you have any questions about this form or instructions, please contact IME Provider Services at 800-338-7909, or if within the local Des Moines area call 515-256-4609.

Field No.	Field Name/ Description	Requirements	Instructions
1	Check One	**REQUIRED**	Check the applicable program.
1a.	Insured's ID Number	**REQUIRED**	Enter the Medicaid member's Medicaid number found on the *Medical Assistance Eligibility Card*. The Medicaid Member is defined as the recipient of services who has Iowa Medicaid coverage. The Medicaid number consists of seven digits followed by a letter, i.e., 1234567A. Verify eligibility by visiting the web portal or by calling the Eligibility Verification System (ELVS) at 800-338-7752 or 515-323-9639, local in the Des Moines area. To establish a web portal account, call 800-967-7902.
2	Patient's Name	**REQUIRED**	Enter the last name, first name, and middle initial of the Medicaid member.

3	Patient's Birth Date	OPTIONAL	Enter the birth date and sex of the member.
4	Insured's Name	OPTIONAL	For Medicaid purposes, this will always be the same as the patient. The insured: For Iowa Medicaid purposes, the member is the insured. If the member is covered through other insurance, the policy-holder is the "other insured".
5	Patient's Address	OPTIONAL	Enter the address and phone number of the patient, if available.
6	Patient Relationship to Insured	OPTIONAL	For Medicaid purposes, the insured will always be the same as the patient.
7	Insured's Address		
8	Patient Status	*SITUATIONAL*	REQUIRED, if known. Check boxes corresponding to the patient's current marital and occupational status.
9	Other Insured's Name	*SITUATIONAL*	REQUIRED if the Medicaid member is covered under other additional insurance enter the name of the policy holder of that insurance, as well as the policy or group number, the employer or school name under which coverage is offered and the name of the plan or program. If 11d is "Yes", these boxes must be completed.
9a-d.	Other Insured's Name, etc.	*SITUATIONAL*	REQUIRED if the Medicaid member is covered under other additional insurance enter the name of the policy holder of that insurance, as well as the policy or group number, the employer or school name under which coverage is offered and the name of the plan or program. **Note:** If 11d is "Yes", these boxes must be completed.
10	Is Patient's Condition Related To:		

10a. 10b. 10c.	Employment? Auto Accident? Other Accident?	*SITUATIONAL*	REQUIRED if known. Check the appropriate box to indicate whether or not treatment billed on this claim is for a condition that is somehow work or accident related. If the patient's condition is related to employment or an accident, and other insurance has denied payment, complete 11d, marking the "YES" and "NO" boxes.
10d.	Reserved for Local Use	OPTIONAL	No entry required.
11a-c.	Insured's Policy Group or FECA Number and Other Information	OPTIONAL	For Medicaid purposes, the insured will always be the same as the patient.
11d.	Is There Another Health Benefit Plan?	**REQUIRED**	REQUIRED if the Medicaid member has other insurance, check "YES" and enter payment amount in field 29. If "YES", then boxes 9a-9d must be completed. If there is not other insurance check "NO". If you have received a denial of payment from another insurance, check <u>both</u> "YES" and "NO" to indicate that there is other insurance, but that the benefits were denied. Proof of denials must be included in the patient record. Request this information from the member. You may also determine if other insurance exists by visiting the web portal or by calling the Eligibility Verification System (ELVS) at 800-338-7752 or 515-323-9639, local in the Des Moines area. To establish a web portal account, call 800-967-7902. **<u>Note:</u>** Auditing will be performed on a random basis to ensure correct billing.
12	Patient's or authorized person's	OPTIONAL	No entry required.

	signature		
13	Insured or authorized person's signature	OPTIONAL	No entry required.
14	Date of current illness, injury or pregnancy	*SITUATIONAL*	If treatment is related to an accident enter the date of accident or the onset of treatment. Entry should be made in MM/DD/YY format. For pregnancy, use the date of the last menstrual period (LMP). This field is not required for preventative care.
15	If the patient has had same or similar illness…	*SITUATIONAL*	REQUIRED for Chiropractors. Chiropractors **must** enter the date of the most current x-ray. Entry should be made in MM/DD/YY format.
16	Dates patient unable to work….	OPTIONAL	No entry required.
17	Name of referring provider or other source	OPTIONAL	No entry required.
17a.	Untitled	**LEAVE BLANK**	This field must be left blank.
17b.	NPI	*SITUATIONAL*	REQUIRED if: The patient is a MediPASS member and the MediPASS provider authorized service, enter the 10-digit NPI of the referring MediPASS provider. If this claim is for consultation, independent lab, or DME, enter the NPI of the referring or prescribing provider. If the patient is on lock-in and the lock-in provider authorized service, enter the NPI of the lock-in Primary Care Provider (PCP).

18	Hospitalization Dates Related to Current Services	OPTIONAL	No entry required.
19	Reserved for Local Use	OPTIONAL	No entry required. **Note:** Pregnancy is now indicated with a pregnancy diagnosis code in field 21. If unable to enter a diagnosis code to indicate pregnancy in 21, enter "Y-pregnant" in this field.
20	Outside lab	OPTIONAL	No entry required.
21	Diagnosis or nature of illness or injury	**REQUIRED**	Indicate the applicable ICD-9-CM diagnosis codes in order of importance (1-primary; 2-secondary; 3-tertiary; 4 – quaternary) to a maximum of four diagnoses. If the patient is pregnant, one of the diagnosis codes **must** indicate pregnancy. The pregnancy diagnosis codes are as follows: 640 through 648; 670 through 677; V22; V23. **DO NOT** enter descriptions.
22	Medicaid resubmission	OPTIONAL	No entry required.
23	Prior authorization number	*SITUATIONAL*	REQUIRED if there is a prior authorization, enter the prior authorization number. Obtain the prior authorization number from the prior authorization form.
24A. top shaded portion	Date(s) of Service/NDC	*SITUATIONAL*	REQUIRED for provider-administered drugs. Enter qualifier "N4" followed by the NDC for the drug referenced in 24d (HCPCs). No spaces or symbols should be used in reporting this information.
24A. lower portion	Date(s) of Service	**REQUIRED**	Enter month, day and year under both the From and To categories for each procedure, service, or supply.
24b.	Place of Service	**REQUIRED**	Using the chart below, enter the number corresponding to the place service was provide. **DO NOT** use alphabetic characters.

			11 – Office **12** – Home **21** – Inpatient Hospital **22** – Outpatient Hospital **23** – Emergency room – hospital **24** – Ambulatory surgical center **25** – Birthing center **26** – Military treatment facility **31** – Skilled nursing… **32** – Nursing facility **33** – Custodial care facility **34** – Hospice **41** – Ambulance – land **42** – Ambulance – air or water **51** – Inpatient psychiatric facility **52** – Psychiatric facility – partial hospitalization **53** – Community mental health center **54** – Intermediate care facility/mentally retarded **55** – Residential substance abuse treatment facility **56** – Psychiatric residential treatment center **61** – Comprehensive inpatient rehabilitation facility **62** – Comprehensive outpatient rehabilitation facility **65** – End-stage renal disease treatment **71** – State or local public health clinic **81** – Independent laboratory **99** – Other unlisted facility
24c.	EMG	OPTIONAL	No entry required.
24d.	Procedures, services, or supplies	**REQUIRED**	Enter the codes for each of the dates of service. **DO NOT** list services for which no fees were charged. **DO NOT** enter the description.

			Enter the procedures, services, or supplies using the CMS Healthcare Common Procedure Coding System (HCPCS) or valid Current Procedural Terminology (CPT). When applicable, show HCPCS code modifiers with the HCPCS code.
24e.	Diagnosis pointer	**REQUIRED**	Indicate the corresponding diagnosis code from field 21 by entering the number of its position, i.e., 3. **DO NOT** enter the actual diagnosis code in this field, doing so will cause the claim to deny. **Note:** There is a maximum of four diagnosis codes per claim.
24f.	$ Charges	**REQUIRED**	Enter the usual and customary charge for each line item billed. The charge must include both dollars and cents.
24g.	Days or Units	**REQUIRED**	Enter the number of times this procedure was performed or number of supply items dispensed. If the procedure code specifies the number of units, then enter "1." When billing general anesthesia, the units of service must reflect the total minutes of general anesthesia.
24h.	EPSDT/ Family Plan	*SITUATIONAL*	REQUIRED if services are a result of an EPSDT Care for Kids screen or are for family planning services. Enter "F" if the service on this claim line is for family planning. Enter "E" if the services on this claim line are the result of an EPSDT Care for Kids screening.
24i.	ID. Qual.	**LEAVE BLANK**	This field must be left blank.
24J. top	Rendering Provider ID. #	**LEAVE BLANK**	This field must be left blank.

shaded portion			
24J. Bottom portion	NPI	**REQUIRED**	Enter the NPI of the provider rendering the service.
25	Federal Tax I.D. Number	OPTIONAL	No entry required.
26	Patient's Account No.	OPTIONAL	Enter the patient account number assigned to the patient by the provider of service. This field is limited to 10 alpha/numeric characters.
27	Accept Assignment?	OPTIONAL	No entry required.
28	Total Charge	**REQUIRED**	Enter the total of the line item charges on the LAST page of the claim. If more than one claim form is used to bill services performed, only the last page of the claim should give the claim Total Charge. The pages prior to the last page should have "continued" or "page 1 of __" in Box 28.
29	Amount Paid	*SITUATIONAL*	REQUIRED if the member has other insurance **and** the insurance has made a payment on the claim. Enter only the amount paid by other insurance. Member co-payments, Medicare payments or previous Medicaid payments are not listed on this claim. Do not submit this claim until you receive a payment or denial from the other carrier. Proof of denials must be included in the patient record. If more than once claim form is used to bill services performed and a prior payment was made, the third-party payment should be entered on ***each page*** of the claim in Box 29.
30	Balance due	**REQUIRED**	Enter the amount of total charges less the amount entered in field 29.

			If more than one claim form is used to bill services performed, only the last page of the claim should give the claim Balance Due. The pages prior to the last page should have "continued" or "page 1 of __" in Box 30.
31	Signature of Physician or Supplier	**REQUIRED**	Enter the signature of either the physician or authorized representative and the original filing date. If the signature is computer-generated block letters, the signature must be initialed. A signature stamp may be used. The signatory must be someone who can legally attest to the service provided and can bind the organization to the declarations on the back of this form.
32	Service Facility Location Information	**OPTIONAL**	Enter the complete address of the treating/rendering provider.
32a.	NPI	**OPTIONAL**	Enter the NPI of the facility where service(s) were rendered.
32b.	Untitled	**LEAVE BLANK**	This field must be left blank.
33	Billing Provider Info & Phone #	**REQUIRED**	Enter the name and complete address of the billing provider. **Note:** The address **must** contain the zip code associated with the billing provider's NPI. The zip code **must** match the zip code confirmed during NPI verification.
33a.	NPI	**REQUIRED**	Enter the NPI of the billing provider.
33b.	Untitled	**REQUIRED**	Enter the taxonomy code associated with the **billing provider's NPI.** A "**ZZ**" qualifier must precede the taxonomy code. **Note:**

			The taxonomy code **must** match the taxonomy code confirmed during NPI verification.

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